ADVERSE DRUG REACTION REPORTING FORM

Section I - To be completed by the individual reporting the adverse drug reaction

1. Occurrence date *(day, month, year)*	2. Adversity occurred: ☐ Outpatient ☐ Inpatient	3. Age	4. Sex	5. Suspected drug

6. Dosage	7. Route	8. Other drugs the patient is taking

9. Onset of reaction *(In relation to drug administration.)*

☐ Immediate ☐ Within _____ hours ☐ Within _____ days ☐ Within _____ weeks

10. Relevant lab *(I.e., drug serum concentrations, electrolytes, etc.)*

11. Description of the problem *(Select all that apply. If none of the selections apply, write a descriptive note in "other.")*

☐ Rash	☐ Nausea	☐ Fever	☐ Hypertension
☐ Mental status changes	☐ Vomiting	☐ S.O.B.	☐ Hypotension
☐ Dizziness, ataxia	☐ Diarrhea	☐ arrhythmia	☐ Blood dyscrasias (anemia, thrombocytopenia, neutropenia)

☐ Other: _____

_____

12. Action *(Responses to "a" through "e" are mandatory. Response to "f" is required if applicable.)*

a. Documented reaction in medical records ☐ Yes ☐ No
b. Notified the prescriber ☐ Yes ☐ No
c. Dosage was adjusted ☐ Yes ☐ No
d. Drug was discontinued ☐ Yes ☐ No
e. Drug level was ordered ☐ Yes ☐ No

f. Treatment needed: _____

_____

_____

13. Follow up:

14. Patient outcome: ☐ Discharged ☐ Admitted ☐ Other:

15a. Printed name of person submitting this report	15b. Signature	15c. Date

SPECIAL INSTRUCTIONS TO SUBMITTOR: Stop here. Ensure an impression of the patient's medical stamp plate has been made below in the space indicated or, if the stamp plate is not available, that the required information has been printed legibly. Fold this form once, insert it in a U.S. Government Messenger Envelope (i.e., shotgun envelope) and expeditiously deliver it to the Chief, Pharmacy Service.

Section II - To be completed by the Chief, Pharmacy Service

16. Control number:	Number	Month	Day	Year	17. The patient's reaction(s) was/were documented in literature ☐ Yes ☐ No

18. Comments:

19. Findings were forwarded to: ☐ The P&T Committee ☐ The FDA ☐ Pharmacy Computer Profile ☐ Other:

20a. Printed name of reviewer *(must be a pharmacist)*	20b. Signature	20c. Date

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*